

Workers' Compensation Insurance Information

Claim Number: _____ Date of Injury: _____

Policy Number: _____ Body Part: _____

All Billings and Medical Records To:

Insurance Administrator: The American Equity Underwriters, Inc.

Address: 3850 N Causeway Blvd., Suite 1600
Metairie, LA 70002

Telephone Number: (888) 285-2562 **Facsimile Number:** (888) 453-2562

Employer Contact: _____ Telephone Number: _____

Accident Description: _____

Physician Name: _____

Clinic Name: _____

Address: _____

Telephone Number: _____ Facsimile Number: _____

Diagnosis: _____

Condition is: Related to Employment Not Related to Employment

Requested Services: _____

Work Status: Totally Disabled Partially Disabled Full Duty Release

Restrictions: _____

Date Employee May Return to Work: _____

Treatment Authorized By: _____

Signature: _____ Date: _____